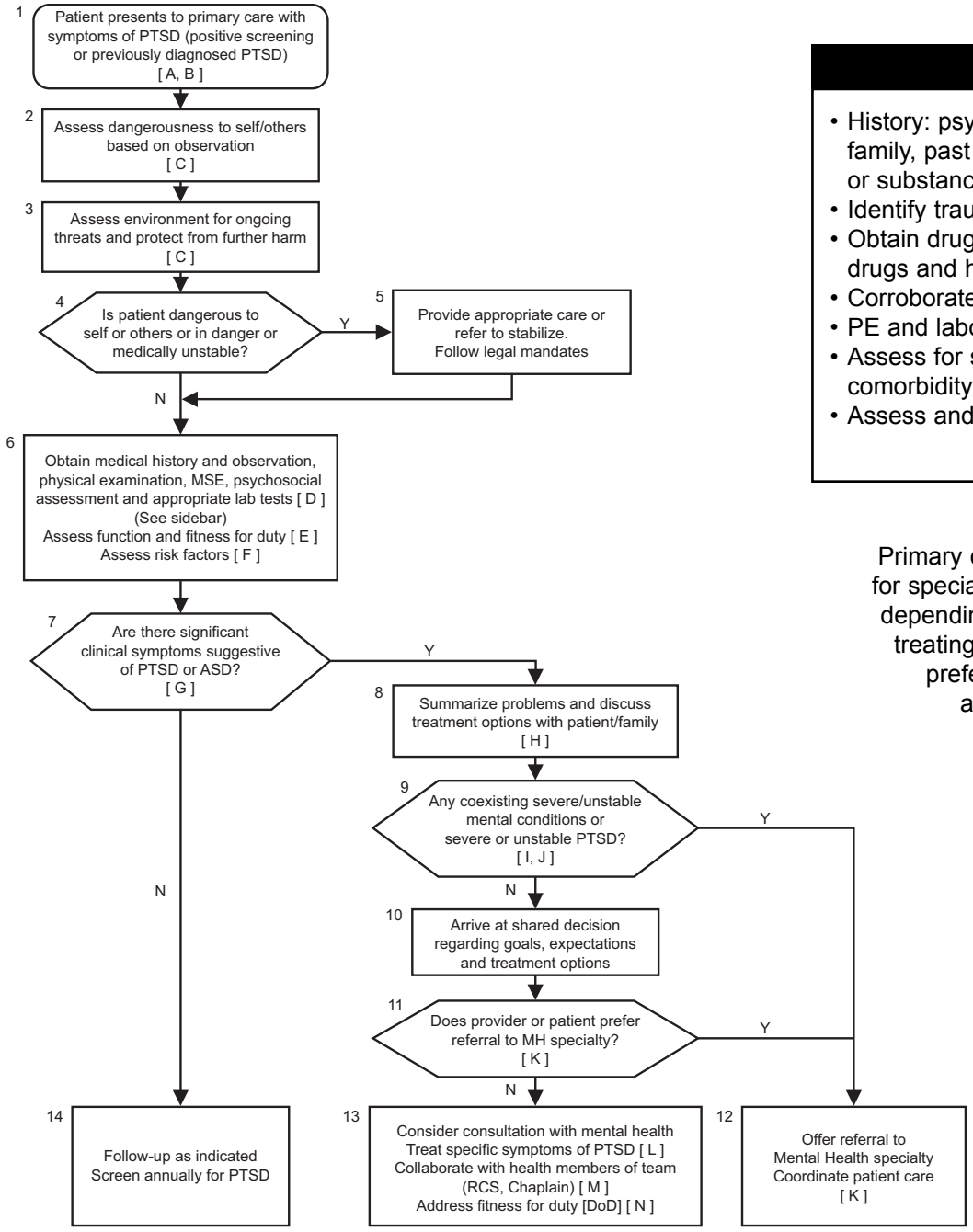
VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST TRAUMATIC STRESS

Module B Summary

POST TRAUMATIC DISORDERS IN PRIMARY CARE

Module B: ASD & PTSD in Primary Care



ASSESSMENT

- History: psychiatric, medical, military, marital, family, past physical or sexual abuse, medication or substance use, social and spiritual life
- Identify trauma history and duration
- Obtain drug inventory (including over the counter drugs and herbals)
- Corroborate evaluation with family/significant other
- PE and laboratory tests - evidence of trauma
- Assess for signs of trauma, substance use, or comorbidity
- Assess and assure safety of self and others [D]

Primary care clinicians may decide to refer for specialized psychiatric care at any point, depending on how comfortable they are in treating PTSD, the particular needs and preferences of the patient and the availability of other services

VA access to full guideline: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guideline: http://www.qmo.amedd.army.mil/

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ANNOTATIONS

A. Assessment of Trauma Exposure Related Symptoms

BACKGROUND

Posttraumatic stress disorder (PTSD) is the development of characteristic and persistent symptoms along with difficulty functioning after exposure to a life-threatening experience or to an event that either involves a threat to life or serious injury. In some cases the symptoms of PTSD disappear with time, whereas in other cases they persist for many years. PTSD often occurs with or precedes other psychiatric illnesses.

The symptoms required for the diagnosis of PTSD may be divided into 3 clusters and should be present for at least 1 month.

- **Intrusion or re-experiencing** - memories of the trauma or "flashbacks" that occur unexpectedly; these may include nightmares, intrusive mental images or extreme emotional distress and/or physiological reactivity on exposure to reminders of the traumatic event
- **Avoidance** - avoiding people, places, thoughts, or activities that bring back memories of the trauma; this may involve feeling numb or emotionless, withdrawing from family and friends, or "self-medicating" by abusing alcohol or other drugs
- **Hyperarousal** - feeling "on guard" or irritable, having sleep problems, having difficulty concentrating, feeling overly alert and being easily startled, having sudden outbursts of anger.

Diagnostic criteria for acute stress disorder (ASD) require a presentation of **dissociative** symptoms - numbing, reduction in awareness, derealization, depersonalization or dissociative amnesia.

Patients are most likely to present to primary care with unexplained somatic and/or psychological symptoms, e.g., case sleep disturbance, night sweats, fatigue, difficulty with memory or concentration, etc. In some cases, primary care practitioners (PCPs) may consider PTSD early and use this guideline first; whereas in others, it may be useful to follow the algorithms and recommendation of the DoD/VA guideline for post deployment, the VA/DoD guideline for medically unexplained symptoms or the VA/DoD guideline for management of depression in primary care. All these guidelines provide a link to this module when appropriate.

RECOMMENDATIONS

Assessment in Primary Care

1. Patients who are presumed to have symptoms of PTSD or who are positive for PTSD on the initial screening should receive specific assessment of their symptoms.
2. A thorough assessment of the symptoms is necessary for accurate diagnosis, rating the severity of the disorder and making correct clinical decisions.
3. Consider self-administered checklists to ensure systematic, standardized and efficient review of the patient's symptoms.
4. Useful information may include details such as time of onset, frequency, course, severity, level of distress, functional impairment, and other relevant information.

Table B-1. Common Symptoms After Exposure to Trauma or Loss			
Physical	**Cognitive/Mental**	**Emotional**	**Behavioral**
• Fatigue • Muscle tremors • Chest pain • Elevated blood pressure • Thirst • Visual difficulties • Grinding teeth • Dizziness • Chills • Fainting • Nausea • Twitches • Difficulty breathing • Rapid heart rate • Headaches • Vomiting • Weakness • Profuse sweating • Shock symptoms	• Poor attention • Change in alertness • Memory problems • Poor problem solving • Poor decisions • Increased or decreased awareness of surroundings • Difficulty identifying familiar objects or people • Intrusive images • Poor abstract thinking • Nightmares • Confusion • Poor concentration • Hyper-vigilance • Blaming someone • Loss of orientation to time, place, person	• Anxiety • Grief • Severe pain • Fear • Loss of emotional control • Apprehension • Agitation • Inappropriate emotional response • Guilt • Denial • Emotional shock • Uncertainty • Depression • Feeling overwhelmed • Irritability	• Change in activity • Suspiciousness • Inability to rest • Pacing • Emotional outbursts • Hyper-alert to environment • Erratic movements • Somatic complaints • Withdrawal • Alcohol consumption • Antisocial acts • Change in speech pattern • Loss of or increased appetite • Startle reflex intensified • Change in sexual functioning • Change in communication

Initial screening is discussed in the CORE module (See Core Module annotation E; For Screening Tools –see appendix C).

The DSM-IV (1994) describes three-symptom clusters characteristic of PTSD (reexperiencing, avoidance, and arousal).

The traumatic event is persistently **reexperienced** in one (or more) of the following ways:

1. Recurrent and intrusive, distressing recollections of the event, including images, thoughts, or perceptions
2. Recurrent distressing dreams of the event
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated)
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Persistent **avoidance** of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings or conversations associated with the trauma
2. Efforts to avoid activities, places or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

Persistent symptoms of increased **arousal** (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response.

Diagnostic criteria for ASD require a presentation of **dissociative** symptoms in addition to one symptom of each of the three PTSD symptom clusters. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

1. Subjective sense of numbing, detachment or absence of emotional responsiveness
2. Reduction in awareness of his or her surroundings (e.g., "being in a daze")
3. Derealization
4. Depersonalization
5. Dissociative amnesia (i.e., inability to recall an important aspect of the trauma).

Dissociative symptoms are not considered an essential feature of PTSD, as they are for ASD. Dissociative symptoms included among the diagnostic criteria for PTSD are categorized as reexperiencing (e.g., dissociative flashbacks) or avoidance. A number of symptoms of avoidance could be characterized as dissociative. For example, the dissociative symptom of numbing could be considered an expression of a restricted range of affect and, hence, an avoidance symptom in the PTSD diagnosis. Feeling detached or estranged from others (another avoidance symptom in PTSD) might also be an example of the dissociative symptom of detachment. Similarly, the inability to remember an important aspect of the trauma describes the dissociative symptom of amnesia. Stupor, another dissociative symptom, is characterized as a decrease in activity that is both spontaneous and responsive. Symptoms of stupor could be interpreted as a decreased interest or participation in significant activities, thereby qualifying as another avoidance symptom of PTSD. Thus, while dissociation has not been identified as a central feature of PTSD, dissociative symptoms can contribute to a diagnosis of PTSD, making the comparison of ASD and PTSD less inconsistent than it might seem.

B. Assessment Of Trauma Exposure

RECOMMENDATION

1. Assessment of the trauma exposure should include:
   - History of exposure to traumatic event(s)
   - Nature of the trauma
   - Severity of the trauma
   - Duration and frequency of the trauma
   - Age at time of trauma
   - Patient's reaction at time of trauma (e.g., helplessness, horror and fear)
   - Existence of multiple traumas.
2. When assessing trauma exposure, the clinician must consider the patient's ability to tolerate the recounting of traumatic material since it may exacerbate PTSD symptoms.
3. The assessment should be performed cautiously, especially in situations where the trauma source is still present and the patient perceives himself or herself to be in danger.

C. Assessment Of Dangerousness To Self Or Others

RECOMMENDATION

1. All patients with ASD/PTSD should be assessed for safety and dangerousness including current risk to self or others, as well as historical patterns of risk:
   - Suicidal or homicidal ideation, intent (plan), means (e.g., weapon, excess medications), history (e.g., violence or suicide attempts), behaviors (e.g., aggression, impulsivity), comorbidities (substance abuse, medical conditions)
   - Family and social environment – including risks to the family
   - Ongoing health risks or risk-taking behavior
   - Medical/psychiatric comorbidities or unstable medical conditions.
   - Consider potential to jeopardize mission in operational environment.

D. Obtain Medical History, Physical Examination, MSE And Laboratory Tests

Obtain comprehensive patient data in order to reach a working diagnosis.

A wide range of medical conditions and treatments may result in abnormal behavior. Many medical disorders may produce or exacerbate psychiatric symptoms in patients with pre-existing mental illness. Multiple studies indicate high rates of medical disease (24 to 50 percent) in patients presenting with psychiatric symptoms. Failure to detect and diagnose underlying medical disorders may result in significant and unnecessary morbidity and mortality. The converse problem is far greater in primary care: patients present with somatic symptoms and have psychiatric disorders that are not properly diagnosed or treated. In one study, 5 of 6 patients with a psychiatric diagnosis had a somatic presentation and the primary care physician made the diagnosis only half the time; whereas for the 16% with a psychological complaint, the correct diagnosis was made 94% of the time. A standardized approach to medical evaluation, including a thorough history, physical examination, laboratory evaluation, and occasionally other ancillary testing, prevents the omission of important aspects of the evaluation.

RECOMMENDATIONS

1. All patients should have a thorough medical and psychiatric history, with particular attention paid to the following:
   - Baseline functional/mental status
   - Past medical history
   - Medications: to include herbal & over-the-counter (OTC) drugs
   - Past psychiatric history: to include: prior treatment, past hospitalization for depression or suicidality, and substance use disorders
   - Current life stressors

   If trauma exposure is recent (<1 month) particular attention should be given to the following:
   - Exposure to/environment of trauma
   - Ongoing traumatic event
   - Exposure, perhaps ongoing, to environmental toxin
   - Ongoing perceived threat
2. All patients should have a thorough physical examination. On physical examination, particular attention should be paid to the neurological exam, stigmata of physical/sexual abuse, self-mutilation, or medical illness. Note distress caused by or avoidance of diagnostic tests/examination procedures.
3. All patients, particularly the elderly, should have a mental status examination (MSE) to include assessment of the following:
   - Appearance and behavior
   - Language/speech
   - Thought process (loose associations, ruminations, obsessions) and content (delusions, illusions and hallucinations)
   - Mood (subjective)
   - Affect (to include intensity, range and appropriateness to situation and ideation)
   - Level of consciousness (LOC)
   - Cognitive function
4. All patients should have routine laboratory screening tests including TSH, Complete Metabolic Panel, Hepatitis, HIV, and HCG (for females). Also consider CBC, UA, Tox/EtoH panel and other tests as clinically indicated.
5. Other assessments may be considered (radiology studies, ECG and EEG) as clinically indicated.
6. All patients should have a narrative summary of psychosocial assessments to include work/school, family, relationships, housing, legal, financial, unit/community involvement, and recreation as clinically appropriate.

E. Assessment Of Functioning

One of the key goals of care is to assist the individual in beginning to return to a normal level of function. The clinician or caregiver must assess the individual's current state of health and functioning. Whenever possible, this should include assessment of any physical injuries, assessment of the individual's level of functioning and level of family and relationship functioning.

RECOMMENDATION

1. Assessment of global function should be obtained, such as the Global Assessment of Function (GAF) scale or the SF-36.

Global Functional Assessment

Consider using instruments such as the GAF (American Psychiatric Association, 1994) or the SF-36 (McHorney, 1994) to assess global function. Such measures are useful for directing therapeutic interventions and monitoring response to treatment.

Narrative Functional Assessment

Functional assessment must be considered from the patient's point of view as well as from the clinician's point of view. A narrative account provides a more complete picture of the patient and his/her response to trauma. It allows for targeted social and behavioral interventions. Components of functional assessment should include: work/school, relationships, housing, legal, financial, unit/community involvement, and recreation.

Table B-2. Functional Assessment

Work	• Any changes in productivity? • Have co-workers or supervisors commented on any recent changes in appearance, quality of work or relationships? • Tardiness, loss of motivation, loss of interest? • Been more forgetful, easily distracted?
School	• Changes in grades? • Changes in relationships with friends? • Recent onset or increase in acting out behaviors? • Recent increase in disciplinary actions? • Increased social withdrawal?
Family Relationships	• Negative changes in relationship with significant others? • Irritable or easily angered by family members? • Withdrawal of interest in or time spent with family? • Any violence within the family?
Recreation	• Changes in recreational interests? • Decreased activity level? • Poor motivation to care for self? • Sudden decrease in physical activity? • Anhedonia?
Housing	• Does the person have adequate housing? • Are there appropriate utilities and services (electricity, plumbing, etc)? • Is the housing situation stable?
Legal	• Are there outstanding warrants, restraining orders or disciplinary actions? • Is the person regularly engaging in, or at risk to be involved in, illegal activity? • Is patient on probation or parole? • Is there family advocacy/Dept. of Social Services (DSS) involvement?
Financial	• Does the patient have the funds for current necessities including food, clothing and shelter? • Is there a stable source of income? • Are there significant outstanding or past-due debts, alimony, child support? • Has the patient filed for bankruptcy? • Does the patient have access to healthcare and/or insurance?
Unit/Community Involvement	• Does the patient need to be put on profile, medical examination board, or limited duty? • Is patient functional and contributing in the unit environment? • Is there active/satisfying involvement in a community group or organization?

F. Assessment of Risk Factors

Following a traumatic event, a majority of those exposed may experience posttraumatic mental responses. However, after 9 to 12 months, 15 to 25 percent continue to be disturbed by these symptoms. This group with persistent symptoms may have distinct psychological, social or biological factors that determine the presence of these ongoing problems.

RECOMMENDATION

1. All patients should be assessed for risk factors for developing ASD or PTSD. Special attention should be given to post-traumatic factors (i.e., social support and functional incapacity) that may be modified by intervention.
2. Because of the high prevalence of psychiatric comorbidities in the PTSD population, assessment for depression and other psychiatric comorbidities is warranted (see also VA/DoD Clinical Practice Guidelines for the Management of MDD and Psychoses).
3. Substance use patterns of persons with trauma histories or PTSD should be routinely assessed to identify substance misuse or dependency (alcohol, nicotine, prescribed drugs, and illicit drugs) (see also VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders).

The following characteristics have been shown to be risk factors for the development of PTSD:

Pre-traumatic factors

- Ongoing life stress
- Lack of social support
- Pre-existing psychiatric disorder
- Other pre-traumatic factors including: female gender, low socioeconomic status, lower level of education, lower level of intelligence, race (Hispanic, Japanese, other ethnic minority), reported abuse in childhood, report of other previous traumatization, report of other adverse childhood factors, family history of psychiatric disorders, poor training or preparation for the traumatic event

Peri-traumatic or trauma related factors

- Severe trauma
- Type of trauma (interpersonal traumas such as torture, rape or assault convey high risk of PTSD)
- High perceived threat to life
- Age at trauma (school age youth, 40-60 years old)
- Community (mass) trauma
- Other peri-traumatic factors including: history of peri-traumatic dissociation and interpersonal trauma

Post-traumatic factors

- Ongoing life stress
- Lack of social support
- Bereavement
- Major loss of resources
- Other post-traumatic factors including: children at home and female with distressed spouse

Individually, the effect size of all the risk factors was modest, but factors operating during or after the trauma, such as trauma severity, lack of social support and additional life stress, had somewhat stronger effects than pretrauma factors

G. Are There Clinical Significant Symptoms Suggestive Of PTSD Or ASD?

Primary care providers should be comfortable performing the initial evaluation and management of ASD and PTSD.

Please refer to Annotation A for a discussion of posttraumatic symptoms.

RECOMMENDATION

1. Primary care providers should formulate a presumptive diagnosis of stress related disorder consistent with the DSM IV criteria for ASD and PTSD.
2. Primary care providers should consider initiating treatment or referral based on a working diagnosis of stress related disorder.
3. Patients with difficult or complicated presentation of the psychiatric component should be referred to mental health specialty for diagnosis and treatment.

DSM-IV Criteria for Stress Disorders

Prior to DSM-IV (American Psychiatric Association, 1994), severe distress occurring in the month after a traumatic event was not regarded as a diagnosable clinical problem. Although this prevented the pathologizing of transient reactions, it hampered the identification of more severely traumatized individuals who might benefit from early interventions. To address this issue, DSM-IV introduced the diagnosis of acute stress disorder (ASD) to describe those acute reactions associated with an increased likelihood of developing chronic PTSD. A diagnosis of ASD is given when an individual experiences significantly distressing symptoms of reexperiencing, avoidance and increased arousal within 4 weeks of the trauma. These symptoms must be present for at least two days before the diagnosis of ASD can be made. The DSM-IV diagnosis of ASD requires that the victim report at least three of the following five symptoms labeled as indicators of dissociation: numbing, reduced awareness of surroundings, derealization, depersonalization, and dissociative amnesia. These requirements are based on evidence found in previous studies that dissociative symptoms at the time of (or shortly after) the traumatic event are predictive of the subsequent development of chronic PTSD. Thus the fundamental differences between PTSD and ASD involve time elapsed since the trauma and the relative emphasis on dissociative symptoms in the ASD diagnosis.

Table B-3. DSM-IV Criteria for Stress Disorders

Diagnostic criteria for 308.3 Acute Stress Disorder (DSM-IV)

A) The person has been exposed to a traumatic event in which both of the following were present:
- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- the person's response involved intense fear, helplessness, or horror

B) Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
- a subjective sense of numbing, detachment, or absence of emotional responsiveness
- a reduction in awareness of his or her surroundings (e.g., "being in a daze")
- derealization
- depersonalization
- dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C) The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D) Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E) Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G) The disturbance lasts for a minimum of 2 days and a maximum of **4 weeks** and occurs within 4 weeks of the traumatic event.

H) The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder

Table B-4. DSM-IV Criteria for Stress Disorders (continued)

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder (DSM-IV)

A. The person has been **exposed to a traumatic event** in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently **reexperienced** in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed
   (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content
   (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent **avoidance** of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect (e.g., unable to have loving feelings)
   (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased **arousal** (not present before the trauma), as indicated by two (or more) of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is **more than 1 month.**

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if: **Acute:** if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

DSM-IV & DSM-IV-TR Cautionary Statement

- The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills.
- These diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field. They do not encompass, however, all the conditions for which people may be treated or that may be appropriate topics for research efforts.
- The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.

H. Patient Education

Help trauma survivors cope with ASD/PTSD by providing information that may help them manage their symptoms and benefit from treatment.

Education of the trauma survivor is a core part of all PTSD treatment. Survivors need to better understand what they are experiencing, how to cope with reactions or symptoms and what happens in treatment. It is also helpful to provide this information to family members or to the patient's significant others so that they can more effectively support the patient's recovery.

RECOMMENDATIONS

1. Trauma survivors should be educated about PTSD symptoms, other potential consequences of exposure to traumatic stress, practical ways of coping with traumatic stress symptoms, processes of recovery from ASD/PTSD, and the nature of treatments.

I. Coexisting Severe Mental Conditions

Improve management of PTSD symptoms when they are complicated by the presence of a medical or psychiatric comorbidity.

Comorbid medical and psychiatric conditions are important to recognize, because they can modify clinical determinations of prognosis, patient or provider treatment priorities, and setting where PTSD care will be provided. Patients with PTSD have been found to frequently report physical symptoms and to utilize high levels of medical care services. Providers should also expect that 50 to 80 percent of patients with PTSD have one or more coexisting mental disorders. Some comorbid medical or psychiatric conditions may require early specialist consultation in order to assist in determining treatment priorities. In some cases, these disorders may require stabilization before (or in concert with) initiating PTSD treatment.

RECOMMENDATIONS:

1. Primary care providers should recognize that medical disorders/symptoms, mental disorders, and psychosocial problems commonly coexist with PTSD and should screen for them during the evaluation and treatment of PTSD.
2. Consider the existence of comorbid conditions when deciding whether to treat patients in the primary care setting or refer them for specialty mental health care.

Comorbid conditions and psychosocial problems of greatest interest to the primary care provider include:

1. *Medical conditions:* Some medical disorders may restrict PTSD treatment options (e.g., dementia limits psychotherapeutic options; cardiac conduction problems may limit some pharmacotherapeutic options; and disorders that restrict mobility may limit ability to attend weekly treatment sessions). It is generally best to maximize medical management of these conditions first and then focus on PTSD treatment.
2. *Substance use disorders:* Patients with PTSD frequently use alcohol and other substances in maladaptive ways to cope with their symptoms. (Approximately 40 to 50 percent of PTSD patients treated in the VA have current substance use problems (See annotation J) Effective PTSD treatment is extremely difficult in the face of active substance use problems unless substance use disorders are also treated. Most often, attempts to address substance problems should proceed concurrently with the direct management of PTSD. However, in cases when the substance use is severe, substance use may require initial treatment and stabilization before progressing to PTSD care (e.g., patient requires detoxification from opiates) (see Annotation I - Concurrent PTSD and Substance Abuse).
3. *Psychiatric disorders:* In addition to substance use disorders, other commonly occurring mental disorders that co-exist with PTSD include: major depression, dysthymia, panic disorder, obsessive-compulsive disorder, and agoraphobia. Treatment of these disorders often occurs concurrently with therapy for PTSD, but on occasion they will take precedence. These disorders have evidence-based therapies that may pose additional effective treatment options. Comorbid disorders that are less common with PTSD, but not rare, include psychotic disorders and bipolar disorder, and somatization or medically unexplained physical symptoms. Practitioners should be alert to comorbid eating disorders, such as bulimia, particularly in women.
4. *Personality disorders:* Personality disorders are long-term problems of coping that begin in childhood or adolescence and are often associated with past abuse or neglect and recurrent relationship problems. These patterns often result in poor adherence to prescribed PTSD management. The primary care provider may require early assistance and advice from the mental health care provider.

5. Psychosocial problems: Associated behavior problems and psychosocial deficits commonly present in patients with chronic PTSD include:
   - Homelessness
   - Suicidality
   - Domestic violence or abuse
   - Explosive aggression
   - Chronic pain, medically unexplained symptoms and "somatization"

The clinician will need to determine the best strategy for prioritizing and treating multiple disorders. One key decision concerns whether these disorders should be treated concurrently or consecutively. Another choice point is whether PTSD and its psychiatric comorbidities should be treated in the primary care setting or referred to specialty mental health care. A number of guidelines or principles should be considered in making these treatment decisions:

- Integrated care models have several advantages, where the physical and mental health needs of patients are addressed in a single setting by a multi-disciplinary provider team.
- In systems where integrated care models do not exist, consultation and comprehensive assessment by a mental health provider are recommended.
- In general, referral to specialty mental health is indicated if a patient with PTSD has comorbid mental disorders that are severe or unstable. (Examples include: patients whose depression is accompanied by suicidality, patients with substance dependence disorder and patients with concurrent psychotic or bipolar disorder.) If the patient is referred to mental health for treatment of PTSD, then it is usually best for the mental health provider to provide comprehensive treatment for all mental disorders.
- Primary care clinicians may decide to refer for specialized psychiatric care at any point, depending on how comfortable they are in treating PTSD, the particular needs and preferences of the patient, and the availability of other services.

A number of logistical, provider, and resource restrictions may also influence the decision about how to best provide treatment for patient's comorbid disorders.

Factors to consider when developing the most appropriate treatment plan include:

- Local resource availability (mental health, primary care, integrated care, vet centers, other)
- Level of provider comfort and experience in treating psychiatric comorbidities
- Patient preferences
- The need to maintain a coordinated continuum of care for chronic comorbidities
- Availability of resources and time in engaging in the treatment of the diseases

For patients referred to specialty mental health care, it is important to preserve the continuity of care by ensuring ongoing communication with the primary care provider and to coordinate care when multiple providers are involved.

J. Concurrent PTSD and Substance Abuse

OBJECTIVE

Improve management of PTSD symptoms when they are complicated by a concurrent substance abuse problem.

BACKGROUND

Clinicians should note that substance abuse may mask or suppress PTSD symptoms, causing an individual to apparently fail to meet criteria for PTSD diagnosis.

RECOMMENDATIONS

1. Substance use patterns of clients with trauma histories or PTSD should be routinely assessed (see the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders).
2. Substance abusers should be routinely screened for trauma exposure and PTSD.
3. Integrated PTSD-substance abuse treatment should be considered.
4. Substance-abusing patients with PTSD should be educated about the relationships between PTSD and substance abuse, referred for concurrent PTSD treatment or provided with integrated PTSD/substance abuse treatment.
5. Substance abuse-PTSD patients should receive follow-up care that includes a continued focus on PTSD issues.

K. Referral To Mental Health Specialty

Provide guidance for primary care providers on optimal referral for PTSD patients.

Patients with PTSD have a complex and often challenging presentation. Evidence regarding the effectiveness of treatment modalities at this point is severely limited, but there is good evidence that cognitive behavioral therapy (CBT) is an effective intervention for ASD and PTSD. (See Module C for details of mental health treatment.)

RECOMMENDATIONS

1. Primary care providers should consult with a mental health provider and/or a PTSD Specialty Team for all patients with acute or chronic stress disorders.
2. Primary care providers should continue to be involved in the treatment of patients with acute or chronic stress disorders.
3. Treatment for patients with acute stress disorder or acute or chronic PTSD should involve a multi-disciplinary team approach to include OT, spiritual counseling, recreation therapy, social work, psychology and/or psychiatry.
4. Patients with clinically significant symptoms or co-morbidities to PTSD, including chronic pain, insomnia, anxiety, and depression, should receive treatment for those complicating problems.
5. Case Management should be provided, as indicated, to address high utilization of medical resources.
6. Consider referral for alternative care modalities as indicated for patient symptoms, consistent with available resources and resonant with patient belief systems.

L. Treatment in Primary Care

Primary care providers often treat patients with mental health disorders. Many options are available to primary care providers to treat stress-related disorders and to relieve the burden of suffering for ASD/PTSD patients, including pharmacotherapy, supportive counseling, hypnosis, and referral resources.

Since people who develop ASD are at greater risk of developing PTSD, they should be identified and offered treatment as soon as possible. Research suggests that relatively brief but specialized interventions may effectively prevent PTSD in some subgroups of trauma patients.

RECOMMENDATIONS

ALL PATIENTS with Stress Related Disorders

1. A supportive and collaborative treatment relationship or therapeutic alliance should be developed and maintained with patients with ASD/PTSD inclusive of their input in treatment planning.
2. Primary care providers should routinely provide the following services for all patients with stress related disorders, especially those who are reluctant to seek specialty mental health care:
   - Supportive counseling
   - PTSD-related education
   - Regular follow-up and monitoring of symptoms
   - Early recognition of PTSD
3. Primary care providers should consider consultation with mental health providers for patients with ASD/PTSD, who warrant a mental health referral but may be reluctant or refuse it.
4. Primary care providers should take leadership in convening a collaborative team for patients with PTSD. Team members may include the primary care providers, mental health specialists, chaplains, pastors, social worker, occupational or recreational therapists, Vet Centers, family support centers, exceptional family member programs, VA benefit counselors, peer-support groups, and others.

ASD

5. Because ASD does not occur in all people who later develop PTSD, consider treatment for acutely traumatized people with ASD, with severe PTSD symptoms as well as for those who are incapacitated by acute psychological or physical symptoms.
6. Patients with ASD should be monitored for development of PTSD. The use of validated PTSD symptom measure such as the PTSD Checklist should be considered (see Appendix D).
7. Primary care providers should consider pharmacologic management of disruptive symptoms (e.g., sleep) (see Pharmacotherapy for ASD).
8. Brief (4 to 5 sessions) of cognitive behavioral therapy (CBT) is an effective early intervention for patients with ASD. In addition to targeted brief interventions, some trauma survivors may benefit from follow-up provision of ongoing counseling or treatment.

PTSD

9. All patients with PTSD should have a specific primary care provider assigned to coordinate their overall healthcare.
10. Pharmacologic management of PTSD or related symptoms may be initiated based on a presumptive diagnosis of PTSD. Long-term pharmacotherapy will be coordinated with other intervention once the patient has been referred to the mental health clinic (see Pharmacotherapy for PTSD).
11. Primary care providers should perform a brief PTSD symptom assessment at each visit. The use of a validated PTSD symptom measure, such as the PTSD Checklist, should be considered (see Appendix D).
12. Primary care providers should assess patients with PTSD for associated high-risk behaviors (e.g., smoking, alcohol/drug abuse, HIV and hepatitis risks) and comorbid medical and psychiatric illnesses.

DISCUSSION

Establishing Therapeutic Alliance

Many people with PTSD find that their relationships with others have changed as a result of exposure to trauma. They often report that they have difficulty trusting others, are suspicious of authority, dislike even minor annoyances, and generally want to be left alone. Since the doctor-patient relationship draws heavily on trust, respect and openness, and since the relationship often has to be formed in a bureaucratic setting, the doctor may find the PTSD patient to be withholding, negativistic or even hostile at the initial meeting. He or she may seem to have "an attitude." Over the years, many combat veterans have been misunderstood and misdiagnosed by otherwise competent professionals over exactly this dynamic. In transference terms, it's as if the patient brings to the initial meeting the full force of the traumatic experience. He may take on the persona of the combat soldier, the rape victim, or the assault or accident victim. If a therapeutic relationship is to have any opportunity to develop, the treatment provider often must make an internal shift from being a medical or psychiatric detective to being open, available and honest on a personal level. Some providers naturally relate in this way, but others have found that they are most useful when they "put on the white coat" and withdraw into a detached "professional" role. Unfortunately, medical schools and graduate schools often teach this role. But, with the combat veteran as with most patients, the truly professional stance is one of caring and concerned involvement. The provider who relates from a stilted, defensive role will meet a veteran who does the same. If the provider wants to assist the patient in finding and re-developing trust in a core identity that has been shifted by combat or sexual assault, the provider must relate from his/her own core identity. In short, the clinician who can relate honestly and openly is more likely to have a patient who is willing to relate to him/her as a fellow human being and an effective partner in treatment.

A general understanding of what has happened to the veteran is critical in this process of developing a therapeutic relationship. Every provider working with combat veterans should be advised to read some basic material on the experience of combat and watch videotape of the same. Unsettling though it may be, the provider must understand the feelings of profound rage and grief that are involved in traumatic experiences. These feelings will be present in the interview setting and must be met with respect at a minimum. Another useful way to think about the combat veteran is that the individual has been subjected to an experience that has moved them away from their center and at the same time has developed a persona with PTSD diagnostic characteristics. At first, it may seem that this person has no real center in much the same way that a person with borderline personality disorder seems to lack a center. Their identity seems to have been redefined by their traumatic experience, and the provider is not accustomed to dealing with the features of this apparent new identity. The requirement is simply to first understand this aspect of the veteran's persona, and then to accept it, empathize with it, get curious about it, and welcome it home. The veteran himself is struggling with exactly the same tasks.

PTSD Treatment

Pharmacologic management of PTSD and related symptoms

It is usually feasible, depending on the provider's confidence and motivation in treating PTSD, to consider offering pharmacological therapies within the primary care setting.

- The symptom relief that medication provides allows most patients to participate more effectively in psychotherapy when their condition may otherwise prohibit it.
- Acute (emergency room) administration of propranolol in the immediate aftermath of a traumatic event appeared to prevent the later development of physiological hyperreactivity but neither reduced ASD nor prevented subsequent PTSD.
- Antidepressant medications may be particularly helpful in treating the core symptoms of PTSD—especially intrusive symptoms.

Refer to the evidence-based pharmacologic strategies for ASD and PTSD, summarized in the section on Pharmacotherapy Intervention of this guideline. The section also includes medication tables that summarize indications/benefits, contraindications/adverse effects and usual dosages.

Supportive Counseling

Primary care-based supportive counseling for PTSD has received little study to date and cannot be endorsed as an evidence-based psychotherapeutic strategy. However, it may be the sole psychotherapeutic option available for the patient with PTSD who is reluctant to seek specialty mental health care. Elements for primary care-based supportive counseling for PTSD include helping patients brainstorm and solve problems of everyday living and problems presented by PTSD symptoms and sequelae (e.g., agoraphobia or other phobic avoidance), provision of PTSD-related psychoeducation, assisting patients in recognizing early signs and symptoms of PTSD relapse, and encouraging initiation of active coping strategies such as physical activity, relaxation strategies, and social and recreational activities.

Regular follow-up and monitoring

Regular follow-up with monitoring and documentation of symptom status should be part of primary care treatment of any chronic disease. Primary care providers should perform a brief PTSD symptom assessment at each visit (no more than quarter-annually is usually needed for the patient with apparently stable PTSD symptoms). The mnemonic "DREAMS" is an effective way for some primary care providers to remember cardinal PTSD symptom domains:

- **D**etachment
- **R**eexperiencing the event
- **E**vent had emotional effects
- **A**voidance
- **M**onth in duration (symptoms for >1 month)
- **S**ympathetic hyperactivity or hypervigilance

The use of a pencil-paper measure of PTSD symptom severity such as the PTSD Checklist (see appendix D PCL) should be considered. Scores on the PCL may be plotted serially over time to create a longitudinal record of symptom severity and may be helpful for recognizing environmental (e.g., renewed proximity to a previously abusive parent) or seasonal (e.g., anniversary of a traumatic war event) precipitants of PTSD symptoms.

Early recognition of a psychosocial crisis and referral to specialists

Primary care providers may be the first to recognize that a patient with PTSD is entering a related psychosocial crisis. Depending on the severity and disability associated with the crisis and the potential for harm to the patient or others, the primary care provider may be obliged to obtain specialty mental health services, even if that patient is reluctant to seek those services.

Coordination of general health care

The traditional role of the primary care provider as the coordinator of various disciplines and consultants involved in the treatment of any single patient is especially relevant for the patient with PTSD. Particularly in patients with chronic PTSD, medically unexplained symptoms or problems with substance use (including smoking) may lead to the need for a wide range of specialists. Coordination of these services is important to avoid confusion and unnecessary health care use.

M. Referral To Vet Centers

OBJECTIVE

Provide timely mental health services to veterans in need of support.

BACKGROUND

There are 206 Vet Centers nationwide that provide Readjustment Counseling Services (RCS) to combat era

veterans. They are located in seven regions: Northeast, Mid-Atlantic, Central, Southeast, Southwest, Western Mountain and Pacific Western (http://www.va.gov/rcs). Legislation passed by Congress and signed into law by the President changed eligibility for Vet Center services (Public Law 104-262) and extended definition of the Vietnam era for war zone veterans (P.L. 104-275). Vet Centers serve the following veterans (see VHA DIRECTIVE 97-002, Jan. 9, 1997, for eligibility details):

- War Zone Veterans (all eras), including: Vietnam War, Korean War, World War II, and American Merchant Marines
- Vietnam era Veterans not in the War Zone: Lebanon, Grenada, Panama, Persian Gulf, and Somalia
- Operation Joint Endeavor, Operation Joint Guard and Operation Joint Forge
- Sexually traumatized while in the military

Vet Center services include individual readjustment counseling, referral for benefits assistance, group readjustment counseling, liaison with community agencies, marital and family counseling, substance abuse information and referral, job counseling and placement, sexual trauma counseling, and community education.

RECOMMENDATIONS

1. Veterans with symptoms of PTSD should have an initial assessment of needs.
2. Veterans who are dangerous to self or others should be referred to the local VAMC or nearest emergency room.
3. Veterans who are seeking to have basic needs met should be referred to the VA Homeless Coordinator or community resources for food, shelter, or emergency financial assistance.
4. Veterans who are eligible for Vet Center services should have an in-depth psychosocial history taken, including a comprehensive military history and treatment plan.
5. Treatment plans in the Vet Center may include individual, family, or group therapy. Veterans can receive medical treatment or medication management at the Vet Center by a psychiatrist, RN, or ARNP or be referred to the local VAMC, CBOC, or community resources.
6. Veterans who are eligible for Vet Center services should be made aware of the Center resources and referred if the patient desires.

N. Assess Duty/Work Responsibilities And Patient's Fitness (In Relation To Military Operation)

Ideally, service members who become ineffective as a result of PTSD will be returned to duty at the earliest possible time. For most military specialties the time to enlist and train the soldier to minimal operational readiness often exceeds a year. Consequently, service members who become ineffective due to stress related conditions constitute a significant source of trained personnel who potentially have much to offer despite their disability. Assessment of fitness to duty may also have implications for medical boards and vocational rehabilitation.

RECOMMENDATION

1. The determination of when to return a service member to duty should take into consideration the individual's service member's role, the complexity and importance of his job, and the service member's functional capabilities.
2. The continuing presence of symptoms of PTSD should not be considered as the sole basis for preventing a return to duty.

Practitioners who are managing patients suffering from stress reactions or PTSD should consider a variety of factors when deciding when the individual is ready to return to work or military duty.

First, what is the patient's job and level of responsibility? Patients in lower skill jobs (e.g., truck drivers, food service personnel, and basic supply functions) can be expected to function effectively despite continuing anxiety. In addition, the cost of functional failure of individuals in these roles is likely limited. In contrast, patients in higher skill jobs or those that involve more potent risks (e.g., artillery forward observers, combat controllers, physicians, and pilots) should not be returned to duty unless there appears to be a high probability that they have resumed effective functioning. Individuals in leadership positions should be required to demonstrate a higher level of reconstitution as errors on the part of these individuals can potentially lead to much greater consequences.